Indiana Access to Recovery (ATR) – Client Choice Form

INATR – 001 – Marion

I Sally Smith, IDOC#_____ understand that Indiana Access to Recovery is a voluntary
(Enter Client's Name) (If applicable)
program and that my participation in the program is because I want to recover from my addictions. I understand that there are a number of providers qualified to provide any service that I may require during my participation in the ATR program. I also understand that I may choose the providers that provide services to me while I participate in the program. I understand that the following providers are ready to provide Indiana ATR clients with recovery consultation.

Name of Organization	Phone	Fax	Disclosure
ANSAR	317-291-4444	317-713-1141	Required
Community Outreach Network Services	317-710-3074	317-328-8932	Not Required
Rich Recovery Services	317-926-5822	317-926-0604	Required
Women Entrepreneurs of America – Project Return	317-890-0933	317-890-0904	Not Required
MSD of Wayne Township – Adult Education Program	317-248-8616	317-243-5537	Required
PACE/OAR	317-612-6800	317-612-6811	Required
Volunteers of America	317-234-1931 Ext. 238 or 317- 432-4080	317-234-1939	Not Required
Workforce, Inc.	317-532-1367	317-532-1369	Required
Julian Center (female clients only)	317-941-2200	317-937-7093	Not Required
The Way to Recovery	317-946-2844 (female clients) or 317-985-5907 (male clients)	317-328-3437(f) 765-483-9844 (m)	Not Required
Calvary Temple of Indianapolis	317-897-7100	317-897-7983	Required
Family Service of Central Indiana	317-634-6341 x201	317-464-9575	Not Required
Wheeler Mission Ministries	317-636-2720	317- 686-0488	Required

From the above list I have selected Volunteers of America to provide this service.
(Enter Name of Recovery Consultant)

I understand that some of the providers listed above either offer services in addition to recovery consultation or are affiliated with agencies that offer other ATR services. If this is the case, a disclosure is required.

No one has exerted pressure on me to select this particular provider and I am confident that this provider is best suited to meet my needs for recovery consultation. I understand that if I find that this provider does not meet my needs, I may select another provider to replace this provider at any time. I understand that Volunteers Of America may not be willing or have the ability to
(Enter Name of Recovery Consultant)
provide recovery consultation to me, in which case I will need to select a different provider.

I understand that the Recovery Consultant will need to contact me.
I authorize my chosen Recovery Consultant to contact me by contacting me at the following:

Address: 123 Recovery Road

Home Phone: 317-555-5555 Cell Phone: none Work Phone: none

I authorize the referral agency to release my information to help the Recovery Consultant contact me:

Referral Agency: Life Recovery Center

Referral Agent: Donny Davis Phone: 317-222-2222

Sally Smith 2/9/09
Client Signature Date

Fax all IDOC referrals to Amanda Copeland: 317-233-1474 (fax)

IN access to RECOVERY
CLIENT CENTERED AND RECOVERY FOCUSED

Indiana Access to Recovery (ATR) – Client Consent to Participate

INATR – 002 – 11/26/2008

1- ATR Client Name: Sally Smith **Date:** 2/9/09

2- Have you ever received ATR services anywhere in the state of Indiana? ☐ Yes ☒ No

3- Are you chemically dependent or addicted to alcohol or another drug? ☒ Yes ☐ No

4- Are you legally a minor or juvenile? ☐ Yes ☒ No

5- When you are not in treatment, where do you live? 123 Recovery Road, Indianapolis IN 46201

6- What county is that in? Marion

7-How many family members live in your household? 2

8- What is your annual household income? 10,000

9- Have you used Methamphetamine in the last 90 days? ☐ Yes ☒ No

10- Have you ever used Methamphetamine? ☐ Yes ☒ No

11- Have you been released from prison, jail, or another correctional facility in the 6 months? ☐ Yes ☒ No

12- Will you be released from prison, jail, or another correctional facility in the next 6 months? ☐ Yes ☒ No

13- (If client is a woman) Are you pregnant, or do you have dependant children? ☒ Yes ☐ No

14- Are you entering this program because you want to actively participate in recovery? ☒ Yes ☐ No

15- Did anyone tell you that you had to enter the ATR program? ☐ Yes ☒ No

16- Do you want to actively work to recover from substance abuse or addiction? ☒ Yes ☐ No

Under penalty of perjury, I affirm that the information in this "Client Consent to Participate" form is correct.

Sally Smith
Client Signature

2/9/09
Date

I recognize that I am responsible for my recovery and I will do everything in my power to recover from my substance abuse or addiction, and will do everything in my power to assist those individuals that agree to help me as I recover from my substance abuse or addiction.

Sally Smith
Client Signature

2/9/09
Date

For ATR Eligibility Questions, please call your Indiana ATR County Representative.

IN access to RECOVERY
CLIENT CENTERED AND RECOVERY FOCUSED

Indiana Access to Recovery (ATR) – Client Registration Form

INATR- 019

Please complete this form to the best of your ability. This information will be used to enroll you in the Indiana Access to Recovery (ATR) Program. All information will be kept confidential in accordance with state and federal law.

The required fields are noted with a "*" symbol. Please be sure to complete those fields. If you have any questions, your Recovery Consultant will be able to assist you. Thank you.

***Name:** Sally (First) Sue (Middle) Smith (Last)

***Date of Birth:** 1/1/81 ***Gender:** ☐ M ☒ F

***Soc. Sec. #:** 323-23-3323 Race/Ethnicity: Caucasian

Email Address: SSmith@yahoo.com

Home Address: 123 Recovery Road (Street Address) Apt. # Indianapolis (City) IN (State) 46201 (Zip)

Alternate Address: 222 Driveway Dr. (Street Address) 10 (Apt. #) Indianapolis (City) IN (State) 42610 (Zip)

Phone #: 317-555-5555 Cell Phone #: none

Work Phone #: none Other Phone #: Sister 317-455-5555

Driver's License #: 4020 02 0000 Are you a veteran? ☐ Yes ☒ No

Alternate Name/Alias: Sally (First) Johnson (Last)

Please list highest level of education completed: 10th grade

Sally Smith
Client Signature

2/9/09
Date

FOR OFFICE USE ONLY. Please complete and forward to DMHA (317) 233-1986	
Population (mark all that apply): ☐ I ☒ W ☐ M-90 day ☐ M-other ☐ NS	
ATR County: Marion	
Recovery Consultation Org Name: VOA	CC: Initials: AS

CLIENT CENTERED AND RECOVERY FOCUSED

Indiana Access to Recovery (ATR) – GPRA

INATR-018

A. RECORD MANAGEMENT

Client ID |F|I|9|8|9|M|S|0|0|5|9|_|_|_|_|

Client Type:

- ○ Treatment client
- ◉ Client in recovery

Interview Type ***[CIRCLE ONLY ONE TYPE.]***

Intake [GO TO INTERVIEW DATE]

6 month follow-up → → → Did you conduct a follow-up interview? ○ Yes ○ No
[IF NO, GO DIRECTLY TO SECTION I.]

Discharge → → → Did you conduct a discharge interview? ○ Yes ○ No
[IF NO, GO DIRECTLY TO SECTION J.]

Interview Date |0|2|/|0|9|/|2|0|0|9|
Month Day Year

[IF FOLLOW-UP AND DISCHARGE INTERVIEWS: SKIP TO SECTION B.]

[IF METH USER (90 DAY RULE) WRITE METH USER HERE]

IN access to RECOVERY
CLIENT CENTERED AND RECOVERY FOCUSED

Indiana Access To Recovery (ATR)– Client Information Form

INATR - 004

CLIENT GENERAL INFORMATION

Client Name: Sally Smith

ATR Enrollment Date: 2/9/09

Is the address client gave on the Registration Form a permanent address? ☐ Yes ☒ No
If No, please explain (if the client is staying a friend/family member's home or in a shelter/halfway house, please explain here): Currently staying w/ friend on Recovery Road
-No permanent address

If the client gave Alternate address information, please explain:
Gave address of sister on Driveway Dr
(may move in w/ sister once treatment started)

General Information Notes:

CLIENT FAMILY INFORMATION

Is Client Married? ☐ Yes ☒ No

Does Client live with a: ☐ Spouse ☐ Partner/significant other ☐ Girlfriend ☐ Boyfriend ☒ Other Friend

If client does live with someone, what is that person's name? Susan Scott

Spouse/Partner's Phone: Dating guy named Joe Johnson

Does the client have any children? ☒ Yes ☐ No

If Yes, how many? 3

If applicable, does the client have regular contact with their children? ☒ Yes ☐ No

If applicable, are any of the client's children under the age of 14? ☒ Yes ☐ No

If yes, does the client have adequate childcare for the children under 14? ☐ Yes ☒ No

Does the client's spouse or partner have any significant physical health, mental health, or legal issues? ☒ Yes ☐ No If Yes, please explain:

Severe trauma as a child - might have mental health issues

Do any children in the client's family have significant physical health, mental health, or legal issues? ☐ Yes ☒ No If Yes, please explain:

Does the client report any significant issues, health or otherwise, with any extended family members? ☒ Yes ☐ No If Yes, please explain:

Many family members w/ addiction issues

Does the client report that their spouse/partner or other significant family members have a history of substance abuse issues or addiction(s)? ☒ Yes ☐ No
If Yes, please explain: See above

Family Information Notes:

ATR Client Information Sheet

If applicable, list the client's previous criminal charges:

No known criminal charges

Is the client required by a probation/parole officer or as part of a diversion agreement to participate in any type of programming? If yes, please list out all requirements:

n/a

Is the client required by any court (criminal or family) to have contact with a case worker, case manager, or similar professional? ☐ Yes ☒ No If yes, please explain:

Legal Information Notes:

—

MENTAL AND PHYSICAL HEALTH INFORMATION

Does the client report having any physical or mental health issues? ☒ Yes ☐ No.
If Yes, please explain:

PTSD

Please list any medications the client is taking to address any physical or mental health issues.

none currently

Does the client currently have health insurance? ☐ Yes ☒ No
If yes, does that insurance cover mental health or addictions treatment? ☐ Yes ☒ No

Does the client report any current or previous suicidal ideation or attempts? ☒ Yes ☐ No
If Yes, please explain: Childhood trauma led to thoughts ~~of~~ of suicide in early 20s

If the client is currently under the care of a physical and/or mental health professional, (Medical Doctor, Psychologist, Therapist, Counselor), please list that person's name and contact information:

n/a

Has the client ever been enrolled in any type of formal treatment to address their substance abuse/addiction issues? ☒ Yes ☐ No. If Yes, please describe: (include location, therapist name, whether or not the client successfully completed). Attended IOP groups at Midtown, States therapists name is James (doesn't remember last name) — did not complete.

What is the client's substance of choice? (please list all)

Alcohol, history of cocaine use
Smoker

What is the longest amount of time the client has been able to abstain from using substances? (hours, days, weeks, months, etc.) 6 months

Does the client report having any co-occurring addictions? (gambling, sex, shopping, etc)
☒ Yes ☐ No
If Yes, please list:
Gambling

Does the client currently have a sponsor? ☐ Yes ☒ No

Does the client currently attend an NA/AA meeting?
☒ Yes ☐ No If Yes, how often do they attend? About 1 every other week

ATR Client Information Sheet

	If No, is the client aware of local meeting locations? ☒ Yes ☐ No

What methods have been most helpful to the client in addressing their substance abuse or additions issues? Please check all that apply.

- ☐ Participating in a therapy group
- ☐ Participating in a 12-step group
- ☒ Working
- ☒ Listening to music
- ☒ Exercising/Participating in a sport
- ☐ Spending time with their children
- ☐ Other
- ☒ Participating in individual counseling
- ☐ Spending time with friends
- ☒ Attending a religious service
- ☐ Speaking with a minister, pastor, priest, etc.
- ☐ Participating in an art activity or hobby
- ☐ Spending time with a spouse or significant other

What barriers to their recovery do the client report/expect/foresee?

Seems to find herself in destructive relationships

Please list any other government supported programs in which the client currently enrolled (TANF, HIP, DWD programming, Vocational Rehabilitation Programming, etc.):

Applied for TANF, Food Stamps
Considered Voc. Rehab but never applied

Mental/Physical Health Notes:

- Needs Clinical Assessment

CLIENT STRENGTHS INFORMATION

Who does the client identify as a social support? Please list all persons (family, friends, employer, etc.):

Sister - Amy
Friend - Susan
Mother - Ann

What pro-social activities does the client enjoy doing?

Enjoys Sports

What strengths does the client identify about him/herself?

Organized, Detail-oriented, committed

Client strengths notes:

Client seems to be able to reason through decisions -
Employable

ADDITONAL CONTACT INFORMATION

If client cannot be reached at the given phone or alternate phone number, who else can be contacted to try to find him/her? ☐ Spouse/partner ☐ Parole/Probation Officer
☐ Counselor/Therapist
☒ Other If other, give name, contact phone number, and explain relationship to client: Susan, Amy

ATR Client Information Sheet

317-233-3333 (Amy)
317-888-8888 (mother-Ann)

CLIENT EMPLOYMENT and EDUCATION INFORMATION

Is the client employed? ☐Yes ☒No	If yes, name of employer:

Does the client report being satisfied by their current position? ☐Yes ☐No
If No, please explain: n/a

How many days/hours per week does the client work? Spends 15 hours job searching	Please note the client's work schedule (days/nights, hours, etc.). —

Does the client report having a disability that limits or prevents their ability to work? ☐Yes ☒No If Yes, please explain:

Has the client been found eligible for disability insurance? ☐Yes ☒No

If the client is unemployed, are they actively looking for employment? ☒Yes ☐No
If yes, in what field/industry? Would like to find office job - thinks she needs some education to achieve

What is the highest level (grade/degree) of education client successfully completed? 10th grade	Does client report having adequate reading abilities? ☒Yes ☐No

Is the client a native English speaker? ☒ Yes ☐ No
If no, does the client need for English as a Second Language (ESL) services? ☐Yes ☐No If Yes, for what language?:

Does client report having any learning disabilities? ☐Yes ☒No
If Yes, please describe:

Does the client report a desire to increase their education level or move into a different type of employment? ☒Yes ☐No If Yes, please explain:
Would like better job than before - needs some formal education

Does the client report that they have any documentation they may need to acquire a job (driver's license, state issued ID card, birth certificate, etc.) ☒Yes ☐No drivers license

Does the client have reliable transportation? ☐Yes ☒No
If no, does the client reside near public transportation (bus/train stop) ☒Yes ☐No (bus passes)

Employment and Education Notes:

CLIENT LEGAL HISTORY/INFORMATION

Is the client currently on probation or parole? ☐Yes ☒No

Probation/Parole officer Name: n/a

Phone number:

If applicable, list the client's current criminal charges:

ATR Client Information Sheet

When arranging for voucher changes/additions via phone client will need to provide a "password" to the Recovery Consultant to confirm their identity prior to the voucher authorization. In the boxes below, please provide password information.

Mother's maiden name: Stanley	Childhood Pet's Name: Fido
Other password: red	Other password clue: favorite color

OTHER RELEVANT INFORMATION/UPDATES

April Schmid
Recovery Consultant Signature

2/9/09
Date

CLIENT CENTERED AND RECOVERY FOCUSED

Indiana Access To Recovery (ATR) – Individualized Recovery Planner - 1

INATR - 006

Client Name: Sally Smith	**ATR Enrollment Date:** 2/9/09

Types of ATR Services available for voucher authorization:

Clinical Treatment Services: Clinical Assessment, Intensive Outpatient Treatment, Independent Dual Diagnosis Treatment, Detoxification

ATR Recovery Services: Transportation, Employment, Continuing Care/Relapse Prevention, Faith-based and Community Support, Substance Abuse Prevention/Education/Intervention, Parenting Support (childcare), Parenting Educational Services, Housing Assistance, GED and Supportive Education, Peer to Peer Services, Family and Marital Counseling, Alcohol and Other Drug Screening

Original IRP – Visit 1	**Date:** 2/9/09

What is client's stated reason for enrolling in ATR?

Enroll (and obtain funding for) programs that will help her stay in recovery

What needs has the client identified that might be barriers to entering or remaining in recovery?

transportation, lack of support, childcare, lack of employment

Type of ATR Service/Program (see list above)	Please list the name of the Certified ATR Provider the client has chosen for the service	Estimated Service Start Date	Estimated Service End Date	Number of Units Authorized
Employment Services	PACE/OAR	2/12/09	3/12/09	20 - individual
Transportation-bus	PACE/OAR	2/12/09	4/12/09	65 units
Parenting Support	Child Empowerment Center	2/12/09	3/12/09	30 units

Original IRP Notes:

Sally Smith
Client Signature

2/9/09
Date

April Schmid
Recovery Consultant Signature

2/9/09
Date

IN access to RECOVERY
CLIENT CENTERED AND RECOVERY FOCUSED

Indiana Access to Recovery (ATR) – Client Choice Form for Service Providers

INATR - 008

I, Sally Smith, understand that Indiana Access to Recovery is a voluntary program and that the purpose of participating in the program is to recover from addictions.

I understand that there are a number of providers qualified to provide any service that I may require during my participation in the ATR program. I also understand that I may choose the providers that provide services to me while I participate in the program.

By signing this document, I affirm that my Recovery Consultant has shown me a list of the service providers that are certified by Indiana Access to Recovery to provide each of the services I have chosen to access. I understand that if I find that any of these providers do not meet my needs, I may select another provider at any time.

I understand that each of the providers I have selected may not be willing or have the ability to provide services to me, in which case I will need to select a different provider.

Through the intake process and development of the Individualized Recovery Plan, I have come to understand that accessing the following services will help me successfully recover from substance use and abuse:

Service: Transportation - bustokens Provider Org: PACE/OAR

Service: Employment Services - Individual Provider Org: PACE/OAR

Service: Parenting Support - Childcare Provider Org: Child Empowerment Center

Service: Provider Org:

Service: Provider Org:

Service: Provider Org:

Sally Smith
Signature

2/9/09
Date

Sally Smith
Print Name

CLIENT CENTERED AND RECOVERY FOCUSED

Indiana Access To Recovery (ATR) – Release of Information

INATR - 009

Client Name: Sally Smith **Date of Birth:** 1/1/1981

Address: 123 Recovery Road, Indianapolis, IN 46201

Section A: The Use and/or Disclosure Being Authorized

Protected Health Information to be Used and/or Disclosed: Specifically and meaningfully describe the protected health information you are authorizing to be used and/or disclosed:

- ☒ Demographic Data
- ☒ Client Information Sheet
- ☒ Individualized Recovery Plan
- ☒ Client Log
- ☒ GPRA information
- ☒ Case Notes
- ☒ Voucher Information Report
- ☒ Voucher Transaction Report

Other: Enter other information to be shared

Section B: Entities Authorized to Receive, Use or Disclose:

Name or specifically identify the persons or *organizations (or the classes of persons and/or organizations)*, including Volunteers of America, who you are authorizing to receive, to make use of, and/or to disclose the protected health information described above:

I authorize information to be: *(check one or both)*

☒ released **TO** Volunteers of America from each and all of the following:

Enter Agency/Individual PACE/OAR	Enter Location 2855 Keystone Ave., Ind., IN 46204
Enter Agency/Individual Child Emp. Center	Enter Location 2828 Street St., Ind., IN 46201
Enter Agency/Individual Ann Stanley	Enter Location 132 Whipporwill, Ind., IN, 46220
Enter Agency/Individual Susan Scott	Enter Location 532 Canterbury, Ind., IN, 46202
Enter Agency/Individual	Enter Location

(Receipt of protected health information is limited to one health care provider per authorization form.)

☒ released **FROM** Volunteers of America to each and all of the following:

Enter Agency/Individual PACE/OAR	Enter Location 2855 Keystone, Ind., IN 46204
Enter Agency/Individual Child Emp. Center	Enter Location 2828 Street St., Ind., IN 46201
Enter Agency/Individual Ann Stanley	Enter Location 132 Whipporwill, Ind., IN 46220
Enter Agency/Individual Susan Scott	Enter Location 532 Canterbury, Ind., IN 46202
Enter Agency/Individual	Enter Location

SECTION C: Purpose

The information is being used/disclosed for the following purpose: Enter reason : help client stay in recovery

Continued on next page:

SECTION D: Expiration and Revocation

Expiration: This authorization will expire

☒ 15 days after my final contact with Indiana Access to Recovery

Or

☐ Enter occurance

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to Volunteers of America. I understand that revocation of this authorization will *not* affect any action taken by Volunteers of America in reliance on this authorization before my written notice of revocation was received. Written revocation should be sent to: Volunteers of America; at 611 North Capitol, Indianapolis, IN.

SECTION E: Alcohol & Drug Abuse Information

I understand that this authorization may include medical records of treatment for physical and/or emotional illness, including treatment of alcohol or drug abuse. I also understand that HIV, or AID's-related information may be released.

SECTION F: Facsimile Communication

I understand that this information may be communicated by facsimile.

SECTION G: The Patient (or the Patient's Legal Representative) Confirming the Authorization

I understand that:

- this authorization is voluntary (you may refuse to sign);
- my health care and payment for my health care will not be affected if I do not sign this form;
- if the organization authorized to receive and/or use the information is not a health plan, health care provider, or health care clearinghouse subject to federal health information privacy laws, the released information may no longer be protected by federal privacy.
- information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and no longer protected.

SIGNATURE:

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to Volunteers of America. I understand that, by signing this form, I am confirming my authorization that Volunteers of America may receive, use, and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature of Patient: Sally Smith _____ Date: 2/9/09

Signature of Legal Representative: _____

42 CFR PART 2:

This information is from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of other information is not for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

CLIENT CENTERED AND RECOVERY FOCUSED

Indiana Access To Recovery (ATR) – Client Contact Log

INATR – 005

Client Name: Sally Smith

Date: 2/9/09 Time: 2-3:30pm Activity: Int. Interview Emp. Name: April S.

Notes: Completed all intake paperwork w/ client. Conducted GPRA interview. Client seemed excited at opportunity to obtain employment services & thinks her participation will help her relationship w/ her kids.

Client Signature: Sally Smith

Date: 2/9/09 Time: 3:30-4:45pm Activity: Int. Admin Emp. Name: April S.

Notes: Completed client file. Entered all client info. into WITS and set up referrals & vouchers for PACE/care & Child Emp. Center.

Client Signature: _____

Date: 2/19/09 Time: 2-2:30 pm Activity: Elect. Contact Emp. Name: April S.

Notes: Spoke w/ client about first employment session at PACE. She is still enthusiastic about program. Set up appt. for Personal Contact on 3/2/09 at 1:30pm.

Client Signature: _____

Date: _____ Time: _____ Activity: _____ Emp. Name: _____

Notes:

Client Signature: _____

Date: _____ Time: _____ Activity: _____ Emp. Name: _____

Notes:

Client Signature: _____

Date: _____ Time: _____ Activity: _____ Emp. Name: _____

Notes:

Client Signature: _____

Date: _____ Time: _____ Activity: _____ Emp. Name: _____

Notes:

Client Signature: _____

IN access to RECOVERY
CLIENT CENTERED AND RECOVERY FOCUSED

Indiana Access To Recovery (ATR) – Individualized Recovery Planner - 2

INATR – 007

As a client uses their authorized units of vouchers and/or their needs change and new services are needed, the IRP should be updated accordingly. The Recovery Consultant should work with the client to make sure they do not attempt to participate in too many services at one time.

IRP UPDATE Information | **Date:** 3/2/09

Has client used all services authorized on previous IRP? ☐ Yes ☒ No

If no, which provider(s) still has unused/authorized vouchers noted on a previous IRP?
Did not use all transportation units - only used 30 units in Feb.

If applicable, what ATR programs/services has the client successfully completed?
Completed 3 individual employment sessions at PACE/OAR

Has the client been given Satisfaction Survey's for each completed program? ☒ Yes ☐ No

When is the client projected to discharge from ATR? 7/9/09

Please note any new needs client has identified as barriers to entering or remaining in recovery?
Client relapsed and is in need of a clinical assessment, possibly IOP & Ind. Addict. Counseling

Type of ATR Service/Program	Please list the name of the Certified ATR Provider the client has chosen for the service	Is this a new type of ATR Service for the client?	Est. Service Start Date	Est. Service End Date	Number of Units Authorized
Clinical Assess.	Midtown	☒ Yes ☐ No	3/15/09	3/15/09	10
IOP	Midtown	☒ Yes ☐ No	3/15/09	5/2/09	12 for 1st 30 days
Transportation	PACE/OAR	☐ Yes ☒ No	3/2/09	4/2/09	35
Employment SVCS	PACE/OAR	☐ Yes ☒ No	3/2/09	4/2/09	4 group

Ongoing IRP Notes:
Will look at adding Community Support in April.

If the Recovery Consultant has authorized services after phone contact with the client, the Recovery Consultant should sign and date the IRP update page on the day it is created. The client is to sign the IRP Update pages at their monthly face-to-face meeting with the Recovery Consultant.

Sally Smith — Client Signature — 2/9/09 — Date

April Smith — Recovery Consultant Signature — 2/9/09 — Date

9/26/2008

IN access to RECOVERY
CLIENT CENTERED AND RECOVERY FOCUSED

Indiana Access to Recovery (ATR) – Client Transfer Form

INATR – 020

I Sally Smith (Enter Client's Name), understand that the Indiana Access to Recovery is a voluntary program and that my participation in the program is because I want to recover from my addictions. I understand that there are a number of providers qualified to provide any service that I may require during my participation in the ATR program. I also understand that I may choose the providers that provide services to me while I participate in the program

From the available Recovery Consultants, I had selected Volunteers of America (Enter Recovery Consultant Agency) to provide me with Recovery Consultation services. At the time this decision was made no one exerted pressure on me to select this particular provider and I was confident that this provider was best suited to meet my needs for recovery consultation. I have found that this provider has not met my needs, so I am selecting another provider to replace my current provider.

From the available Recovery Consultants, I have selected Wheeler Mission (Enter Recovery Consultant Agency) to provide Recovery Consultation Services. No one has exerted pressure on me to select this particular provider and I am confident that this provider is best suited to meet my needs for recovery consultation. I have chosen this agency because the old Recovery Consultation agency was too far away – not easily accessible from the bus line.

I understand that the new Recovery Consultant will need to contact me. I authorize my chosen Recovery Consultant to contact me by contacting me at the following:

Address: 123 Recovery Road, Indianapolis, IN 46201

Home Phone: 317-555-5555 Cell Phone: none Work Phone: none

Sally Smith
Signature

4/15/09
Date